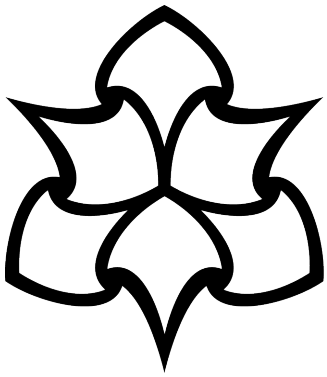

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K.W.M. (Bill) Fulford
Faculty of Philosophy
University of Oxford;
Collaborating Centre for Values-based Practice
St. Catherine's College
University of Oxford, UK

Colin King
Collaborating Centre for Values-based Practice
St. Catherine's College
University of Oxford, UK

Anna Bergqvist
Faculty of Arts and Humanities
Manchester Metropolitan University, UK
https://orcid.org/0000-0003-0154-5355

Hall of Mirrors: Toward an Open Society of Mental Health Stakeholders in Safeguarding against Psychiatric Abuse

Abstract:
This article explores the role of an international open society of mental health stakeholders in raising awareness of values and thereby reducing the vulnerability of psychiatry to abuse. There is evidence that hidden values play a key role in rendering psychiatry vulnerable to being used abusively for purposes of social or political control. Recent work in values-based practice aimed at raising awareness of values between people of different ethnic origins has shown the importance of what we call "values auto-blindness" – a lack of awareness of one's own values as a key part of our background "life-world" – in driving differential rates of involuntary psychiatric

treatment between ethnic groups. It is argued that the vulnerability of psychiatry to abuse stems from values auto-blindness operating on the judgments of rationality implicit in psychiatric diagnostic concepts. Acting like a "hall of mirrors," an international open society of mental health stakeholders would counter the effects of values auto-blindness through enhanced mutual understanding of the values embedded in our respective life-worlds across and between the diverse perspectives of its constituents. The article concludes by noting that a model for the required open society is available in the contemporary interdisciplinary field of philosophy and psychiatry.

Keywords:
abuse of psychiatry, values-based practice, life-world, values auto-blindness, person-centered care, recovery, Austin, Hare, Fanon, Murdoch

Introduction

Psychiatry is notoriously vulnerable to being used abusively for purposes of social or political control rather than for the purposes proper to a clinical discipline. Such abuses became widespread, for example, in the 1960s and 1970s in the former Soviet Union.[1] We return below to this period. But it is far from unique. Similar abuses have occurred in many other parts of the world and at different historical periods.[2]

Nor is contemporary psychiatry immune. As recently as 1999, for example, the UK government launched a major review of the UK's Mental Health Act[3] on a "public safety" ticket.[4] The resultant legislation, moreover, has been and continues to be used disproportionately with particular groups, notably with young black men.[5] Again, we return to this issue below. But evidence of a possible connection between the disproportionate use of involuntary treatment in young black men and political abuses of psychiatry is provided by epidemiological studies suggesting that rates of involuntary treatment in the UK follow administrative boundaries.[6]

Whether or not any given use of psychiatry is abusive may be a matter of debate. But the vulnerability of the field as a whole to abuse can hardly be doubted. So this raises the question, "why?" Why should it be that psychiatry among other medical disciplines is so peculiarly vulnerable to abuse?

One answer to this question, the answer that as we describe further below represents the majority view, is that the vulnerability of psychiatry to abuse arises from (what is perceived to be) its inadequate science base compared with other medical disciplines. In this article we offer a different answer. We argue that the vulnerability of psychiatry to abuse has more to do with its values base than with its science base. To be clear, ours is not a contrarian view. Our view, as will be seen, is that science remains crucially important to best practice in psychiatry. The vulnerability of psychiatry to abuse arises, however, not from inadequate science but from a failure of awareness of and engagement with the values that (as a key element of our background life-worlds) determine how psychiatric science is translated into practice. Gaining insight into our own values, we further argue, requires a relational (rather than individualistic) process. It is in supporting a relational process of this

1) Bloch and Reddaway, *Russia's Political Hospitals*.
2) van Voren and Keukens, *Political Abuse of Psychiatry*.
3) Legislation enabling involuntary psychiatric hospitalisation and/or treatment in the UK.
4) Straw, Central Office of Information (COI), 221, 19.7.1999; Mullen, "Dangerous People with Severe Personality Disorder."
5) Care Quality Commission, *Count Me In 2010*; NHS Digital, 2018
6) Weich et al., "Variation in Compulsory Psychiatric Inpatient Admission in England."

kind that an international open society of mental health stakeholders could help to reduce the vulnerability of psychiatry to abuse.

The article is in four main sections. Section 1, The Evidence, reviews the findings from a study of Soviet psychiatry pointing to the role of values in driving its period of political abuse. Section 2, The Theory, argues that the vulnerability of psychiatry to abuse derives from the particularly diverse nature of the values operative in the areas of human experience and behavior with which psychiatry is characteristically engaged. This diversity of values plays out in the form of hidden values driving the judgments of rationality implicit in psychiatric diagnostic concepts. Section 3, Values Auto-blindness, explains why the values driving abuse remain hidden and, hence, why psychiatry remains vulnerable to abuse. Section 4, The Hall of Mirrors, generalizes the argument of Section 3 to the need for an international open society of mental health stakeholders to counter the effects of values auto-blindness and thus reduce psychiatry's vulnerability to abuse. The article concludes by pointing to the rapidly expanding interdisciplinary field of philosophy and psychiatry as a model for the required open society.

Section 1, The Evidence

Early indications of the potential importance of hidden or otherwise unacknowledged values underlying the vulnerability of psychiatry to abuse came from a study of the scientific publications from Soviet psychiatry during the 1960s and 1970s, the period at which as noted above, political abuses of psychiatry became widespread in the USSR (Union of Soviet Socialist Republics).[7]

The opportunity for the study came when, after the collapse of the USSR, a young Russian psychiatrist, Alex Smirnoff, visited Oxford for a year of work experience in the University Department of Psychiatry. One of us (K.W.M. Fulford) worked on the study with Alex and with a bilingual social work colleague, Elena Snow. Drawing on ordinary language philosophy as practiced notably by the Oxford philosopher, J.L. Austin,[8] we explored Soviet concepts of mental disorder by comparing Russian and "Western" psychiatric science publications during the period in question. Austin called approaches of this kind "philosophical field work" because they involve exploring the meanings of concepts not by reflection but by examining the ways they are actually used in everyday (or ordinary) contexts.[9]

Guided by contemporary views of Soviet psychiatric abuse in Britain and North America, our expectation was that we would find Soviet concepts of mental disorder to be lacking in scientific rigor. Quite to the contrary however, we found that the science of Soviet psychiatry was conceptually identical with its contemporary Western counterparts. Its "delusions of reformism," in particular, were structurally identical with Western mono-symptomatic political delusions; and its diagnostic concept of "sluggish schizophrenia" was structurally identical with the Western "latent schizophrenia." Not only that but Soviet psychiatry shared with Western psychiatry an underlying brain-based disease model of schizophrenia (derived in the Soviet case from the work of the pathologist, IV Davidovsky).

Our conclusion therefore was that the vulnerability, at least of Soviet psychiatry to abuse, could not stem from any essential deficiency in its scientific model compared with prevailing models in use in Western psychiatry. This was of course not as such direct proof that Soviet psychiatric abuse was values-based. But it

7) Fulford, Smirnoff and Snow, "Concepts of Disease and the Abuse of Psychiatry in the USSR."

8) For an authoritative introduction to Austin's ordinary language philosophy see chapter 1 of the biography *J.L. Austin* by one his pupils, the philosopher G.J. Warnock. Warnock, *J. L. Austin*.

9) Austin, "A Plea for Excuses," 25.

left this possibility open. And we speculated in our paper that unacknowledged Soviet political norms were at the heart of the vulnerability of Soviet psychiatry to abuse. In the case of delusions of reformism, for example, Soviet political norms might suggest that people who believed the Soviet system was in need of reform "must…" (to put it bluntly) "…be mad." Other factors, we argued, administrative, professional and so forth, could be important in Soviet abuses becoming widespread and institutionalized. But it was in Soviet political norms, we argued, and in their role in driving diagnostic judgments of rationality, that the essential vulnerability of Soviet psychiatry to abuse was to be found.

So far as we are aware comparable ordinary language studies have not been carried out in other parts of the world where political abuses of psychiatry have become widespread. But growing recognition of the importance of values in psychiatric diagnosis supports the possibility that similar processes may be in play. The North American psychiatrist and philosopher, John Sadler, for example, has used an ordinary language methodology to identify the breadth and diversity of values in the American Psychiatric Association's Diagnostic and Statistical Manual[10] (or DSM);[11] and one of us (Anna Bergqvist) has examined the role of values in shared decision-making in mental health practice.[12] There is thus a prima facie connection here. In the next section we look at two main theories of how the connection operates.

Section 2, The Theory

One widely endorsed theory of the prominence of values in psychiatric diagnosis is that it reflects some (supposed) inadequacy in psychiatric science. This is the line taken, for example, albeit in different ways, by many on both sides of the long-running debate about the validity of the concept of mental illness.[13] Such views are consistent with the widespread perception of the twentieth century medicine that psychiatry is underdeveloped scientifically compared with other specialties. It was this view, combined with an adverse Western view of Soviet psychiatric science, that led to the expectation of inadequate science in the above study of Soviet concepts of mental disorder.

The theory that we adopt in this article, consistently with our overall line on psychiatric abuse, is not science-based but values-based. To anticipate, the bottom line of this theory is that the prominence of psychiatric diagnostic values reflects the diversity of human values operative in the areas of experience and behavior with which psychiatry is characteristically concerned. We do not have space to explore the arguments for and against this values-based theory in detail.[14] Given however its importance in relation to our subsequent arguments about values auto-blindness and the need for a "hall of mirrors," it will be worth considering it a little further before coming to its implications for the vulnerability of psychiatry to abuse.

Our values-based theory is derived from the work of another Oxford philosopher, R.M. Hare. Following Austin,[15] Hare worked on the ordinary language philosophy of values.[16] One of us (K.W.M. Fulford), in his

10) American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*.

11) See Sadler, *Values and Psychiatric Diagnosis*.

12) Bergqvist, "Narrative Understanding, Value, and Diagnosis."

13) See for example, respectively: Szasz, "The Myth of Mental Illness," 113–118, arguing against the concept; and: Kendell, "The Concept of Disease and Its Implications for Psychiatry," arguing for it.

14) See Fulford, *Moral Theory and Medical Practice*, and for an update on the evidence and arguments in question, Fulford and van Staden, "Values-based Practice," 385–412.

15) Austin and Hare were both White's Professors of Moral Philosophy in Oxford.

16) Hare, *The Language of Morals*; and "Descriptivism," 115–134.

turn, applied Hare's work on the language of values to the language of medicine,[17] thus deriving the theoretical basis for what was to emerge a few years later as values-based practice (see below).

Among other important observations about the language of values, Hare pointed out that although values are ubiquitously present and important, we tend to notice them only when they cause trouble and hence come to our attention. Values are in this respect like the air we breathe – this, too, is ubiquitously present and important but noticed only when it causes trouble. Air causes trouble when we get short of it. Values, Hare pointed out, cause trouble when they are diverse and hence come into conflict. Visible values then, on Hare's account, equal diverse values.

One of Hare's examples of "visible values = diverse values" involved comparing fruits like strawberries (where our values are similar) with pictures (where our values are widely diverse). Now, even with strawberries we may have different preferences. But for most people a strawberry that is, say, red, sweet and grub-free, is a good strawberry. With pictures on the other hand we do not have even this degree of agreement. The result, Hare pointed out, is that whereas the expression "good picture" is overtly evaluative, the corresponding expression "good strawberry" carries mainly descriptive meaning: it is taken to mean that the strawberry in question is (consistently with the widely adopted norms for a good strawberry noted above) red, sweet and grub-free. "Good strawberry" according to this view is, no less than "good picture," an evaluative expression. But the evaluative meaning of "good picture" is explicit while that of "good strawberry" is hidden by its descriptive meaning and hence remains largely implicit.

In offering examples of this kind Hare clearly did not have medicine in mind. But his observations neatly explain the prominence of values in psychiatric diagnostic concepts. We can see this by simply mapping Hare's "good strawberry" versus "good picture" example onto a contrast sometimes drawn between "bodily illness" and "mental illness." Thus, where "bodily illness" is like "good strawberry" in that both carry mainly descriptive meaning, "mental illness" is like "good picture" in that both carry overtly evaluative meaning. Hare's observation suggests that this reflects the relative diversity of human values in the areas with which bodily illness and mental illness are respectively concerned. Thus, consistently with Hare's observation, bodily illness is concerned with areas of human experience and behavior (such as pain, loss of mobility, and threat of death) in which (as with "good strawberry") our values are largely *shared*. But mental illness on the other hand is concerned with areas of human experience and behavior (such as emotion, desire, belief, volition and sexuality) where our values (as with "good picture") are highly *diverse*. For this reason alone, then, Hare's observation suggests, for reason solely of the relative diversity of human values in the areas of human experience and behavior with which mental illness is characteristically concerned, values will be more explicit in psychiatric diagnostic concepts than in their bodily medicine counterparts.

Again, we do not have space to acknowledge, let alone do justice to, the many theoretical issues raised by the strategy of applying Hare's observations on the language of values to the language of medicine.[18] The strategy is, however, at least partly justified by its outputs in the development of values-based practice not only in mental health but increasingly in all areas of health care.[19] So derived, values-based practice is essentially

17) Fulford, *Moral Theory and Medical Practice*.

18) We stress that R.M. Hare's wider theoretical commitment to a fact-value dualism plays no part in values-based practice; in this respect values-based practice is closer to the position of the American philosopher; Hilary Putnam presented, for example, in *The Collapse of the Fact/Value Dichotomy and other Essays*.

19) Fulford, Peile and Carroll, *Essential Values-based Practice*.

a partner to evidence-based practice.[20] This is why, as we indicated earlier, ours is not a contrarian account. Our values-based account of the visibility of values in psychiatric diagnosis leaves the challenges of psychiatric science fully in place. But it adds to these scientific challenges a whole series of further challenges arising from the diversity of the values operative in the areas with which psychiatry is characteristically concerned. It was in response to these further challenges that as described elsewhere values-based practice developed first in mental health.[21] Recent case studies, furthermore, in cross cultural values-based mental health practice, are fully consistent with our hypothesized role of psychiatry's diagnostic values in abuse.[22]

Yet fruitful as Hare's observation has been, when it comes to explaining the vulnerability of psychiatry to abuse it leaves a key question unanswered – just why should the values operative in abuse remain hidden? After all, the values in question are in the required sense "causing trouble" (i.e., they are causing abusive uses of psychiatry) so by Hare's observation they should be more not less visible. It is to this question, and to the role of what we will call "values auto-blindness" in answering it, that we turn next.

Section 3, Values Auto-blindness

This section is in part autobiographical in that its key messages about values auto-blindness were born from a project on which two of us (Colin King and K.W.M. Fulford) have worked together over a number of years. The project in question sought to apply the principles of values-based practice to explaining and intervening in the disproportionate use of involuntary psychiatric treatment in young black men. As noted above (in our introduction) this has been a long-standing concern in the UK and elsewhere. It has been variously explained but there are grounds (including epidemiological grounds) for believing that it might represent at least in part yet another example of psychiatric abuse.

In applying a values-based approach to this issue our project was guided by the values-based interpretation of psychiatric abuse outlined in Sections 1 and 2 above. This made it unique in a number of ways. First, reflecting the premise of values-based practice in mutual respect, our guiding principle was (in Colin King's phrase) to work "across the color line," avoiding the "victim/victimizer" polarization of much contemporary work on race and mental health. Second, working within this principle our methods, again following values-based precedents, were co-productive: we brought together our very different backgrounds and expertise with an equality of voice.

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20) Fulford, "Values and Values-based Practice."; Bergqvist, "Narrative Understanding, Value and Diagnosis." The partnership runs deep in that evidence and values are closely intertwined in practice. In Bergqvist, for example, one of us (Anna Bergqvist) applies her particularist account of valuation to show that in shared decision-making it would be a mistake to construe the idea of "expert opinion" as the provision of medical information from a clinical stance that is "objective" in the sense that it is not viewed through the lens of the clinician's own implicit background value commitments. This of course raises the further question of the origins of the values implicit in medical practice. This further question is important if as we argue in this paper the vulnerability of psychiatry to abuse arises from a failure of awareness of implicit background values and of their influence on the judgements of rationality inherent in psychiatric diagnosis. But we must leave this further question aside for now.

21) Fulford, Peile and Carroll, *Essential Values-based Practice.*

22) Mitrev and Mantarkov, "Non-Traditional Religion, Hyper-religiosity and Psychopathology." In the story presented in this chapter, the differential diagnosis between (pathological) delusional and (normal) spiritual beliefs turns directly on cultural and other values implicit in DSM's Criterion B for schizophrenia. Criterion B requires that the patient's "level of functioning in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level (previously) achieved" American Psychiatric Association, *Diagnostics and Statistics Manual*, 99. The authors of this chapter show the extent to which value judgements – reflecting in part but importantly cultural values – are necessary to determining whether the changes in functioning shown by their patient were above or (as required by Criterion B) below the level previously achieved. This and other case studies in Stoyanov et al., *International Perspectives in Values-based Mental Health Practice*; illustrate the extent to which cultural and other values influence all areas of mental health care.

Third as to outputs our aim, consistently with the core aim of values-based practice, was to raise awareness of the values putatively driving the disproportionate use of involuntary treatment with young black men.

It was in raising awareness of values, however, that right from the start we found ourselves struggling. There was evidence that in the UK the use of involuntary treatment was being driven predominantly by values of risk aversion.[23] The hypothesis thus suggested by one of us, K.W.M. Fulford, who is white (and trained in psychiatry), was that young black men might be perceived by service providers as being more at risk than young white men. Colin King however, who is black, argued to the contrary that while it might well be true that young black men were perceived by service providers as being more at risk, the underlying values driving their perceptions of risk (and hence the disproportionate use of involuntary treatment in this group) were of "whiteness." Our project, Colin King suggested, was thus looking the wrong way. Rather than asking "why are young black men more likely than their white counterparts to be subject to involuntary psychiatric treatment?," we should be asking "why are white (or white-trained) psychiatrists more likely to treat young black men than their white counterparts on an involuntary basis?"

K.W.M. Fulford recognized that this suggestion was well founded. He knew that in making it, Colin King was drawing on a long tradition of philosophical and other academic work by black writers such as the North American sociologist and social historian W.E.B. Du Bois[24] and the French West Indian philosopher and psychiatrist Frantz Fanon,[25] viewed through the lens of Colin King's personal experience both as a patient and as a mental health professional.[26] Fanon's work, moreover, being in part linguistic in inspiration, was closely allied to the ordinary language philosophy on which K.W.M. Fulford had drawn in developing values-based practice. Yet for all this it took over ten years working together for (the white) K.W.M. Fulford to gain anything close to insight into what (the black) Colin King meant by "whiteness."

We have described how this came about in detail elsewhere.[27] But in essence it was only when Colin King, K.W.M. Fulford and others subsequently involved in the project[28] came to write up their personal perspectives on working together, that what Colin King meant by whiteness, and how this might impact mental health, became fully apparent to K.W.M. Fulford. Language again played a key role here. The point was made in this instance by another member of the now expanded project, Steven Gillard, who is a white mental health researcher. In his personal perspective Steven pointed out that his (and others') research on race and mental health was invariably written up in the form of third personal commentaries on the first personal experiences of their "research subjects." This, Steven said, had the effect of objectifying the black experience while at the same time hiding from the researchers the values (including the values of whiteness) they brought to their work.

This made sense to (the ordinary-language-philosophy-trained) K.W.M. Fulford. Even so, the insight he gained was only partial. As he described in his own contribution to the book, he remained perplexed by the concept of whiteness, the moreso indeed because of the dissonance he now experienced between intellectual recognition of its likely significance and his lack of any real emotional understanding. He (K.W.M. Fulford) felt rather as he imagined a color-blind person might feel, recognizing the significance of (say) a red traffic light

23) See for example, Royal College of Psychiatrists, *Rethinking risk to others in mental health services*; and Care Quality Commission, *Monitoring the Mental Health Act in 2010/11.*

24) Du Bois, *The Souls of Black Folk.*

25) Fanon, *Black Skin, White Masks.*

26) King, "They Diagnosed Me a Schizophrenic When I Was Just a Gemini."

27) King et al., "*They Diagnosed Me a Schizophrenic When I Was Just a Gemini.*"

28) The project had by now developed into a Network hosted by the Collaborating Centre for Values-based Practice in Oxford – see valuesbasedpractice.org/what do we do/networks and click on Whiteness and Race Equality Network

without actually being able to "see" redness.

In the event emotional understanding required a further intervention from Colin King. Here is how this came about. The write ups of our personal perspectives on working together were the basis for a joint contribution to a book on cultural values and mental health.[29] The book was developed as a co-writing project that involved drafts of its introductory and concluding chapters being circulated to all contributors for comment. As one of the editors, K.W.M. Fulford was responsible for drafting and circulating these materials. Most contributors had only minor or no comments. Colin King, however, pointed out that that despite the understanding provided by Steven Gillard's observations, the standard "research" use of personal pronouns was still in play. As an editor, K.W.M. Fulford was *"speaking in the third person…"* but commenting *"on first person accounts of the black and white cultural challenges…"* with the result that *"your cultural values* [as editors] *are absent."* It was through this comment, and thanks to a subsequent conversation, that I (K.W.M. Fulford) finally began to really see how my own values of whiteness had influenced and were continuing to influence our work together on the project.

This story illustrates just how persistent and deeply ingrained values auto-blindness may be (K.W.M. Fulford's values auto-blindness in this case). But it also shows how it may be overcome. It shows that it is possible to gain not only theoretical insight into it but also emotional understanding of one's own values by way of open-ended dialogue between people with very different perspectives. This is not unprecedented. It is indeed consistent with ideas about the nature of moral or evaluative understanding worked out by yet another Oxford philosopher, Iris Murdoch, and developed by one of us (Anna Bergqvist) in her concept of evaluative perception as being essentially *relational* in character. It is to this work and its implications for generalizing our learning from the above experience to the challenge of reducing the vulnerability of psychiatry to abuse that we turn in the final part of this paper.

Section 4, The Hall of Mirrors

Iris Murdoch's notion of moral vision is standardly represented among philosophers as a criticism of modern moral philosophy's lack of attention to the role of "inner" moral activity in life. While this story is well known within academic moral philosophy, there is another dimension to her emphasis on the *struggle to see* for which one of us (Anna Bergqvist) has argued elsewhere[30] that is more directly relevant to understanding Colin King/K.W.M. Fulford's experience of values auto-blindness, namely the reminder that unless one acknowledges, precisely, the *relational* social dimension of the "inner life" in self-examination, there is limited scope for recognizing one's own values and hence for meeting with the other in a genuine way. Thus, in her 1967 "Sovereignty of the Good", Murdoch writes,

> The enemies of art and of morals … are the same: social convention and neurosis. One may fail to see the individual ... because *we are ourselves sunk in a social whole which we allow uncritically to determine our reactions*, or because we see each other exclusively as so determined. Or we may fail to see the individual because we are completely enclosed in a fantasy world of our own into which we try to draw things from the outside, not grasping their reality and independence, making

29) Stoyanov et al., *International Perspectives in Values-based Mental Health Practice.*

30) Bergqvist, "Moral Perception and Relational Self-Cultivation", "Companions in Love", and "Narrative Understanding, Value and Diagnosis."

them into dream objects of our own.[31]

There are a number of characteristically Murdochian uses of Freudian terms here – "neurosis," "fantasy," "dream object" – that we may or may not find helpful. But the relevance of her core point about uncritical immersion in one's "social whole" to Colin King/K.W.M. Fulford's experience of values auto-blindness is clear. We fail (as K.W.M. Fulford failed) to see the other individual (Colin King in this case) because we are embedded ("sunk") in a "social whole" (K.W.M. Fulford's whiteness). One of us (Anna Bergqvist) has shown how Murdoch's concept of a "social whole" amounts to a "life-world" encompassing a *comprehensive* outlook on reality, an unruly mix of evaluative and non-evaluative claims in complex interaction as a whole.[32]

In Colin King/K.W.M. Fulford's situation the result of being in this way "sunk" in one's individual life-world, was K.W.M. Fulford's values auto-blindness, his persistent inability to really "see" (with emotional as well as merely intellectual insight) the impact on Colin King of the "social whole" life-world of whiteness. Transferred therefore to the context of psychiatric practice – and understood in terms of the theory of the vulnerability of psychiatry to abuse outlined in Sections 1 and 2 – it is easy to see how similar processes of values auto-blindness could lead to abuse. Thus, paraphrasing Murdoch, if in the context of psychiatric practice, "we allow [our whiteness auto-blindness] uncritically to determine our reactions…," the result will be that the values by which the judgments of rationality implicit in psychiatric diagnostic concepts are (in part but essentially) made, will be determined by the "social whole" life-world that the psychiatrist brings to the clinical encounter. This, as such, may not amount to abuse. But it makes psychiatry vulnerable to abuse because it renders psychiatrists (like K.W.M. Fulford) unaware of the values implicit in their "social whole" life-world and of the extent to which these determine the diagnostic judgments on which their interventions (including involuntary psychiatric hospitalization and treatment) directly depend.

So how do we overcome values auto-blindness? This is where the notion of the *relational* nature of evaluative perception in mental health developed by one of us[33] comes in. To anticipate, the relational nature of evaluative perception is derived from fundamental questions raised by Murdoch's later work about relationality and perspective-taking. These lead to the idea that we can come to "see" our own values (as K.W.M. Fulford came to understand whiteness) through open ended dialogue with someone whose life-world gives them a different perspective to that of their own. Metaphorically, we see our own values in the "mirror" provided by the other person's perspective. This is why, extending the metaphor, the "hall of mirrors" provided by an international open society of mental health stakeholders could through mutual illumination of the values embedded in our respective life-worlds, play a role in reducing the vulnerability of psychiatry to abuse.

Thus, in Murdoch's *Existentialists and Mystics* she argues along similar lines to the above, that we are partly obscured in vision "because the world we see already contains our values…"[34] But she then develops a further argument to the effect that recognizing how our vision is obscured by our values (recognizing as we might put it

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31) Murdoch, *Sovereignty of Good*, 216. Emphasis added.

32) Bergqvist, "Moral Perception and Relational Self-Cultivation." Murdoch, in opposition to many academic moral philosophers of her time, maintained that evaluative thought is ubiquitous and all-embracing. She writes, "The area of morals, and ergo of moral philosophy, can … be seen as conveying the whole mode of living and the quality of our relations with the world." Murdoch, *Sovereignty of Good*, 97, 380. The evaluative content of the "social whole" lifeworld is even clearer in Murdoch's earlier work. In her 1956 article "Vision and Choice in Morality," for example, she describes her all-encompassing notion of moral vision as "a person's total vision of life, as shown in their mode of speech or silence, their choice of words, their assessments of others, their conception of their own lives, what they think attractive or praise-worthy, what they think funny." Murdoch, "Vision and Choice in Morality," 39–40.

33) Bergqvist, "Narrative Understanding, Value and Diagnosis."

34) Murdoch, *Existentialists and Mystics*, 200.

our values auto-blindness) carries an obligation for continuous self-cultivation by exercising what she describes as an "*effortful* ability to see what lies before one more clearly, more justly, to consider new possibilities."[35]

One of us (Anna Bergqvist) has argued that there are two claims implicit in this further argument of Murdoch's.[36] It will be worth looking at these briefly as both are relevant to best practice in mental health. The first claim is an epistemic "no priority" claim about knowledge in intersubjective relating, such that neither perspective of the parties involved is prioritized over the other. This is clearly relevant to shared decision-making and co-production as essential elements of best practice in contemporary person-centered recovery-oriented mental health care.[37] The second claim is a claim about the meaning of individual concepts as a function of the wider interpersonal systems in which they operate. It is this second claim that combined with Murdoch's earlier arguments about "social convention and neurosis" which illuminates our concept of values auto-blindness and its relevance to psychiatric abuse. For on this view, communicating across differences in the entrenched "social whole" life-worlds operative in interpersonal encounters in an open-ended way, can serve as a crucial corrective to being overly committed to "*the* voice" of the prevailing norms and ways of seeing the world.

Herein then lies the role of an international open society of mental health stakeholders. The reason for this is simple: within such an open society there is no *single* "voice" but rather a variety of voices reflecting the different perspectives of different "social whole" life-worlds through which, like a hall of mirrors, mutual illumination of our respective values (and their influences on our judgments of rationality) becomes possible. In raising awareness of our own values in this way an international open society of mental health stakeholders would add a crucial new element to the resources of values-based mental health practice. It would add other elements as well.[38] But it is in its role as a hall of mirrors supporting mutual exploration as a way of overcoming values auto-blindness that an international open society of mental health stakeholders would contribute to reducing psychiatry's vulnerability to abuse.

Conclusions

In the introduction to this article we contrasted our values-based approach with the standard science-based understanding of psychiatric abuse. Values and science, however, as we have repeatedly emphasized, should be understood in this context as being essentially complementary. Values-based practice is and has always been conceived as a partner to evidence-based practice. This is a matter partly of theory: evaluations and descriptions although distinct are essentially interdependent in the ordinary language philosophy of values underpinning values-based practice. It is a matter also of practice: as a partner to evidence-based practice in the shared decision-making at the heart of contemporary person-centered clinical care, values-based practice (in the widely used mantra[39]) "links science with people."

The partnership between values-based and science-based approaches is important across the board in healthcare.[40] But it is of particular importance in psychiatry because of the added challenges presented

35) Ibid., 322. Our emphasis.

36) Bergqvist, "Moral Perception, Thick Concepts and Perspectivalism," and "Companions in Love."

37) Fulford, "The State of the Art in Philosophy and Psychiatry."

38) Fulford, "Cultural Values and Mental Health."; and "The State of the Art in Philosophy and Psychiatry."

39) This is the subtitle for example of Fulford, Peile and Carroll's introductory volume, *Essential Values-based Practice*.

40) For example, surgery is currently leading on a number of training and other aspects of values-based practice, Handa et al., "The importance of seeing things from someone else's point of view." For details of this and other actively developing areas of values-based

by the diversity of human values in the areas of human experience and behavior with which, as we have described, psychiatry is characteristically concerned. One result of these added challenges is the need for conceptual philosophical research to stand alongside empirical investigation in psychiatric science. Again, this is not because psychiatric science is as so many have assumed in some way underdeveloped compared with the sciences of other areas of medicine. It is to the contrary because psychiatric science is very much a science *at the cutting edge*.[41] Psychiatric science is in this respect more like theoretical physics than, say, mechanical engineering.

This is why each section of this article has drawn so directly on philosophical insights: on Austin's ordinary language philosophical "field work" in the study of Soviet psychiatric science in Section 1; on R.M. Hare's ordinary language philosophy of values underpinning the values-based theory of abuse presented in Section 2; on Franz Fanon's linguistic studies of whiteness that resulted in the recognition of values auto-blindness in Section 3; and on Iris Murdoch's insights into moral perception that led in Section 4 to the role of an open society of mental health stakeholders as a (metaphorical) Hall of Mirrors for reducing the vulnerability of psychiatry to abuse.

None of these philosophies it is important to add has been uncritically "swallowed whole" as being in any sense the voice of received authority. In each case the philosophy in question has been adapted and developed in a dynamic two-way interaction with the constraints of practice.[42] Austin's philosophical fieldwork (Section 1) was used in conjunction with methods of literature retrieval not available in his day.[43] R.M. Hare's (Section 2) commitment elsewhere in his work to fact-value dualism plays no part in values-based practice (see also footnote 18: as we said there, values-based practice is in this respect closer to the "distinction-not-dualism" position of the American philosopher, Hilary Putnam).[44] The "working across the color line" ethos of the (Section 3) values-based program on whiteness and race equality owes more to Archbishop Desmond Tutu's concept of the "rainbow nation"[45] than it does to the calls for violent resistance to which Franz Fanon came. Iris Murdoch (Section 4) aspired to a degree of objectivity in moral knowledge that is essentially incompatible with the reliance in values-based practice on "little and local" applications of good process.[46]

This is no coincidence. The model adopted here – a model that replaces traditional appeals to philosophical authority with critical engagement by way of dynamic two-way partnerships between philosophy and practice – is the model that has driven developments in the wider field of contemporary philosophy and psychiatry. That the model is one of partnership is perhaps one reason why contemporary philosophy and psychiatry has blossomed in parallel with the blossoming of contemporary cognitive and neuroscience.[47] It is for this reason that we felt it important to emphasize earlier in this article that ours is not a contrarian model but one of partnership.

The model of partnership is also, we believe, why contemporary philosophy and psychiatry has blos-

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practice, see the website for the Collaborating Centre for Values-based Practice in Oxford at valuesbasedpractice.org.

41) Fulford et al., *Oxford Textbook of Philosophy and Psychiatry,* 240–242.

42) The work presented here is part of an on-going programme of collaboration between us from which we will be presenting further materials in subsequent publications.

43) It has been elsewhere integrated with contemporary norms of fieldwork in the social sciences. See Colombo et al., "Evaluating the Influence of Implicit Models of Mental Disorder,"; Fulford and Colombo, "Six Models of Mental Disorder,"; and King et al., *Model Values?*

44) Putnam, *The Collapse of the Fact/Value Dichotomy and other Essays.*

45) Embodied in the philosophy of Nelson Mandela, *Long Walk to Freedom.*

46) Fulford, "Living with Uncertainty."

47) Fulford et al., "Past Improbable, Future Possible."

somed into a collegial international enterprise encompassing the many great traditions of thought and practice available in different parts of the world.[48] As such, the model by its very nature prevents any one particular "voice of authority" becoming dominant, supporting, instead, open-ended exchanges of precisely the kind that we have argued is required to overcome mutual values auto-blindness. The contemporary field of philosophy and psychiatry thus provides a model for the international open society of mental health stakeholders that, we have argued, in offering a Hall of Mirrors to our respective values, could play a key role in reducing the vulnerability of psychiatry to abuse.

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48) Fulford, "The State of the Art in Philosophy and Psychiatry."

49) Birley, "Psychiatric Ethic."

Bibliography:

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* 5th ed., DSM-5. Washington, DC: American Psychiatric Association, 2013. https://doi.org/10.1176/appi.books.9780890425596.

Austin, John L. "A Plea for Excuses." *Proceedings of the Aristotelian Society* 57, (1956–1957): 1–30. Reprinted in *The Philosophy of Action*, edited by Alan R. White, 19–42. Oxford: Oxford University Press, 1968, 19–42.

Bergqvist, Anna. "Companions in Love: Attunement in the Condition of Moral Realism." In *Companions in Guilt Arguments in Metaethics*, edited by Richard Rowland and Christopher Cowie. London: Routledge, 2019. https://doi.org/10.4324/9780429454677-13.

—. "Moral Perception and Relational Self-Cultivation: Reassessing Attunement as a Virtue." In *Ethics and Self-Cultivation: Historical and Contemporary Perspectives*, edited by Sander Werkhoven and Matthew Dennis, 197–221. London: Routledge, 2018. https://doi.org/10.4324/9781315102269-12.

—. "Moral Perception, Thick Concepts and Perspectivalism." In *Evaluative Perception,* edited by Anna Bergqvist and Robert Cowan, 258–28. Oxford: Oxford University Press 2018. https://doi.org/10.1093/oso/9780198786054.003.0014.

—. "Narrative Understanding, Value and Diagnosis: A Particularist Account of Clinical Formulations and Shared Decision-Making in Mental Health." *Philosophy, Psychology and Psychiatry* 27, no. 2 (2020): 149–167. https://doi.org/10.1353/ppp.2020.0023.

Birley, Jim. "Psychiatric Ethics: an International Open Society." In *Two Minds: A Casebook of Psychiatric Ethics* edited by Donna L. Dickenson and K.W.M. Fulford, 327–335. Oxford: Oxford University Press, 2000.

Bloch, Sidney, and Peter Reddaway. *Russia's Political Hospitals: The Abuse of Psychiatry in the Soviet Union*. London: Gollancz; also published in the USA as *Psychiatric Terror,* New York: Basic Books, 1997.

Care Quality Commission. *Count Me In 2010: The National Mental Health and Learning Disability Ethnicity Census.* London: Care Quality Commission and the National Mental Health Development Unit, 2010.

—. *Monitoring the Mental Health Act in 2010/11: The Care Quality Commission's Annual Report on the Exercise of its Functions in Keeping Under Review the Operation of the Mental Health Act 1983*. London: Care Quality Commission, 2011.

Colombo, Anthony, Gillian Bendelow, K.W.M. Fulford, and S. Williams. "Evaluating the Influence of Implicit Models of Mental Disorder on Processes of Shared Decision Making Within Community-Based Multi-Disciplinary Teams." *Social Science & Medicine* 56, (2003): 1557–1570. https://doi.org/10.1016/S0277-9536(02)00156-9.

Du Bois, W. E. B. *The Souls of Black Folk: Essays and Sketches*. Chicago: AC McClurg and Co., 1903. (Released as a free-to-download eBook by the Project Gutenberg January 29, 2008 [EBook #408])

Fanon, Frantz. *Black Skin, White Masks*. Translated by Charles Lam Markmann. New York: Grove Press 1952, 1967.

Fulford, K.W.M., "Cultural Values and Mental Health: A Manifesto for International Values-based Practice." *Eidos. A Journal for Philosophy of Culture* 2, no. 2(*4),* (2018): 136–147. Available at: http://eidos.uw.edu.pl/files/pdf/eidos/2018-02/eidos_4_fulford.pdf.

—. "Living with Uncertainty: a First-Person-Plural Response to Eleven Commentaries on Values-based Practice." In *Debates in Values-based Practice: Arguments For and Against*, edited by Michael Loughlin. Cambridge: Cambridge University Press, 2014.

—. *Moral Theory and Medical Practice*. Cambridge: Cambridge University Press, 1989, reprinted 1995 and 1999.

—. (forthcoming) "The State of the Art in Philosophy and Psychiatry: An International Open society of Ideas Supporting Best Practice in Shared Decision-Making as the Basis of Contemporary Person-Centered Clinical Care." Special Issue of *Phenomenology and Mind on Psychopathology and Phenomenology: Perspectives*. Edited by Marta Boniardi and Elisabetta Lalumera.

—. "Values and Values-based Practice: A Model for Partnership between Philosophy and Science in 21st Century Psychiatry." *Etyka 54*, 2017: 13–27. https://doi.org/10.14394/etyka.502. Available at: https://etyka.uw.edu.pl/index.php/etyka/article/view/502/464.

— and Anthony Colombo. "Six Models of Mental Disorder: A Study Combining Linguistic-Analytic and Empirical Methods." *Philosophy, Psychiatry, & Psychology* 11, no. 2, 2004: 129–144. https://doi.org/10.1353/ppp.2004.0051.

—, Katherine J. Morris, John Z. Sadler, and Giovanni Stanghellini. "Past Improbable, Future Possible: The Renaissance in Philosophy and Psychiatry." In *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry*, edited by K. W. M. Fulford, K. J. Morris, J. Z. Sadler, and G. Stanghellini, 1–41. Oxford: Oxford University Press, 2003. https://doi.org/10.1093/med/9780198526117.003.0001.

—, Ed Peile, and Heidi Carroll. *Essential Values-based Practice: Clinical Stories Linking Science with People*. Cambridge: Cambridge University Press, 2012. Japanese edition, Medical Sciences International (2016). French edition, John Libbey Eurotext (2017).

—, Alex Y.U. Smirnov and Elena Snow. "Concepts of Disease and the Abuse of Psychiatry in the USSR." *British Journal of Psychiatry* 162, (1993): 801–810. https://doi.org/10.1192/bjp.162.6.801.

—, Tim Thornton, George Graham, and Paul Hoff. Introduction to Part III: "Philosophy of Science and Mental Health." In *Oxford Textbook of Philosophy and Psychiatry,* edited by K.W.M. Fulford, T. Thornton, and G. Graham, 240–242. Oxford: Oxford University Press, 2006. NOTE: by kind permission of Oxford University Press, and of the authors, this textbook will be available from July 2020 as a free download (as a whole or as individual chapters with readings) from the website of the INPP (International Network for Philosophy and Psychiatry) at: INPPonline.com/publications/Oxford Textbook of Philosophy and Psychiatry.

— and Werdie van Staden. "Values-Based Practice: Topsy-Turvy Take Home Messages from Ordinary Language Philosophy (And a Few Next Steps)." In *The Oxford Handbook of Philosophy and Psychiatry,* edited by K.W.M. Fulford, M. Davies, R. Gipps, G. Graham, J. Sadler, G. Stanghellini, and T. Thornton, 385–412. Oxford: Oxford University Press, 2013. https://doi.org/10.1093/oxfordhb/9780199579563.013.0026.

Handa, Ashok I., Lucy Fulford-Smith, Zoe E. Barber, Thomas D. Dobbs, K.W.M. Fulford, and Ed Peile. "The Importance of Seeing Things From Someone Else's Point of View." *BMJ Careers* on-line journal, 2016. (Published in hard copy as "Learning to Talk about Values") at: http://careers.bmj.com/careers/advice/The_importance_of_seeing_things_from_someone_else's_point_of_view. https://doi.org/10.1136/bmj.i1652.

Hare, R. M. "Descriptivism." *Proceedings of the British Academy* 49, (1963): 115–134. Reprinted in Hare, R.M. *Essays on the Moral Concepts*. London: The Macmillan Press Ltd., 1972.

—. *The Language of Morals*. Oxford: Oxford University Press, 1952.

Kendell, R.E. "The Concept of Disease and Its Implications for Psychiatry." *British Journal of Psychiatry*, no. 127 (1975): 305–315.

King, Colin, K.W.M. Fulford, Christina Vasiliou-Theodore, and Toby Williamson. *Model Values? Race, Values and Models in Mental Health*. London: The Mental Health Foundation, 2009.

—, et al. *They Diagnosed Me a Schizophrenic When I Was Just a Gemini: The Other Side of Madness and Whiteness*. UK: PCCS Books, forthcoming.

—. "They Diagnosed Me a Schizophrenic When I Was Just a Gemini: The Other Side of Madness." In *Reconceiving Schizophrenia,* edited by Man Cheung Chung, K.W.M. Fulford, and George Graham, 11–28. Oxford: Oxford University Press, 2007. https://doi.org/10.1093/med/9780198526131.003.0002.

Mandela, Nelson. *Long Walk to Freedom: The Autobiography of Nelson Mandela.* Multiple editions; first published in Britain: Little, Brown and Company, a division of the Hachette Book Group, 1994.

Mitrev, I., and M. Mantarkov. "Non-Traditional Religion, Hyper-Religiosity and Psychopathology: the Story of Ivan from Bulgaria." In *International Perspectives in Values-Based Mental Health Practice: Case Studies and Commentaries,* edited by D. Stoyanov, G. Stanghellini, W. Van Staden, MT. Wong, and K.W.M. Fulford, chapter 27. Berlin: Springer Nature, forthcoming.

Mullen, Paul E. "Dangerous People with Severe Personality Disorder." *British Medical Journal* 319 (7218)/1999: 1146–1147. https://doi.org/10.1136/bmj.319.7218.1146. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1116939//articles/PMC1116939/.

Murdoch, Iris. *Existentialists and Mystics: Writings on Philosophy and Literature.* Edited by Peter Conradi. New York: Penguin, 1997.

—. *Sovereignty of Good*. London: Routledge, 1967.

—. "Vision and Choice in Morality." *Proceedings of the Aristotelian Society, Supplementary Volumes* 30, (1956): 14–58. https://doi.org/10.1093/aristoteliansupp/30.1.14.

NHS Digital. "Mental Health Act Statistics, Annual Figures: 2016–17, Experimental statistics." *Mental Health Act Statistics, Annual Figures.* England: NHS, (October 2017). https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/mental-health-act-statistics-annual-figures-2016-17-experimental-statistics.

Putnam, Hilary. *The Collapse of the Fact/Value Dichotomy and other Essays.* Cambridge, Mass., and London, England: Harvard University Press, 2002.

Royal College of Psychiatrists (London). *Rethinking Risk to Others in Mental Health Services: Final Report of a Scoping Group.* College Report CR150. London: Royal College of Psychiatrists, 2008.

Sadler, John Z. *Values and Psychiatric Diagnosis*. Oxford: Oxford University Press, 2005. https://doi.org/10.1093/med/9780198526377.001.1.

Stoyanov, Drozdstoy, Giovanni Stanghellini, Werdie Van Staden, Michael T. Wong, and K.W.M. Fulford. eds. *International Perspectives in Values-Based Mental Health Practice: Case Studies and Commentaries*. Berlin: Springer Nature, forthcoming.

Straw, J. Cited In Central Office of Information (COI), 221, 19.7.1999, In a report on the launch of the Government's consultative paper "Managing Dangerous People with Severe Personality Disorder".

Szasz, Thomas S. "The Myth of Mental Illness." *American Psychologist* 15, (1960): 113–118. https://doi.org/10.1037/h0046535.

van Voren, Robert, and Rob Keukens. "Political Abuse of Psychiatry." In *The Oxford Handbook of Psychiatric Ethics,* edited by John Z. Sadler, W. van Staden, and KWM Fulford, Chapter 48. Oxford: Oxford University Press, 2015. https://doi.org/10.1093/oxfordhb/9780198732365.013.55.

Warnock, G.J. *J. L. Austin*. London: Routledge, 1989.

Weich Scott, et. al. "Variation in Compulsory Psychiatric Inpatient Admission in England: a Cross-Sectional, Multilevel Analysis." *Health Services and Delivery Research* 2, no. 49 (2014). https://doi.org/10.3310/hsdr02490.